Provider Type: Pediatric Primary Care Provider
Area of Concentration: Children/Youth with Behavioral Health Needs

Project: Ambulatory

Area of Concentration: Children/Youth with Behavioral Health Needs

Provider Type: Pediatric Primary Care Provider

Objective: To integrate primary care and behavioral health services for the purposes of better coordination of the preventive and chronic illness care for children/youth with behavioral health needs and children/youth in the child welfare system.

Unless otherwise stated, demonstration that the practice has met the criteria listed in each Milestone Measurement is due by September 30th of the respective Milestone Measurement Period.

Pediatric PCP Ambulatory Project		
Core Component	**Milestone**	**Due Date**
1	Utilize a behavioral health integration toolkit and practice-specific action plan to improve integration and identify level of integrated healthcare	2/28/18
8	Utilize the Arizona Opioid Prescribing Guidelines for chronic pain	4/30/18
2	Identify high-risk members and develop an electronic registry Identify criteria is being used and recorded	5/31/18 9/30/18
3	Utilize practice care manager(s)for members included in the high-risk registry Demonstrate the care manager(s)have been trained to use integrated care plans	6/30/18 9/30/18
4	Implement the use of an integrated care plan and develop communication protocols with MCO's and providers	9/30/18
5	Screen all members to assess SDOH	9/30/18
6	Identify community based resources	9/30/18
7	Screen all members for behavioral health disorders	9/30/18
9	Participate in the health information exchange with Health Current	9/30/18
10	Identify community-based resources, at a minimum through use lists managed by MCO's	9/30/18
11	Prioritize access to appointments for all individuals listed in the high-risk registry	9/30/18
12	Develop protocols for using Trauma-Informed Care for those in the high-risk registry	9/30/18
13	Develop communication protocols in agreement with ASD	9/30/18
14	Ensure medical staff complete ASD training program	9/30/18
15	Develop procedures to provide parent support	9/30/18
16	Develop protocols for those with ASD to facilitate transitions from pediatric to adult providers	9/30/18
17	Develop a protocol for obtaining records for those in child welfare system and their medication needs	9/30/18
18	Schedule office visits for children/youth in welfare system	9/30/18
19	Complete after-visit summary for foster parents/guardians/case worker with recommendations and confidentiality policy	9/30/18
20	Participate in relevant TI program-offered training	9/30/18

Provider Type: Pediatric Primary Care Provider
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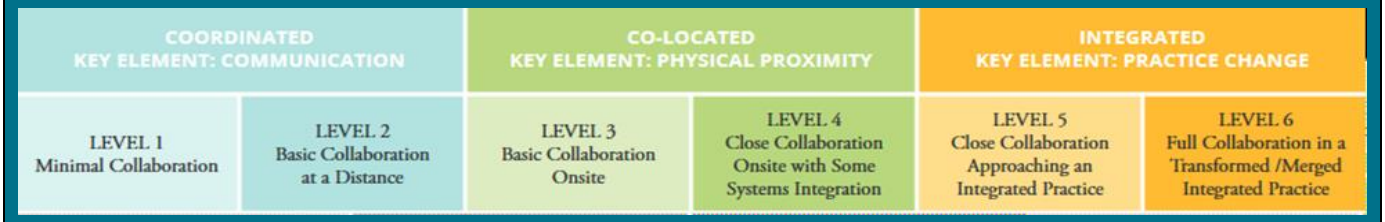
1.

A. Utilize a behavioral health integration toolkit, to develop a practice-specific action plan to improve integration, building from the self-assessment results that were included in the practice's Targeted Investment application.

One of the three toolkits listed here [Organizational Assessment Toolkit (OATI) ; Massachusetts Behavioral Health Integration Toolkit(PCMH) and PCBH Implementation Kit] may be used to inform the development of a practice action plan to improve integration. Practices are welcome to use a behavioral health integration toolkit with which they may have already been working, or find one that fits their needs and practice profile.

B. Identify where along the *Levels of Integrated Healthcare* continuum the practice falls (see table below). To do so, please complete the Integrated Practice Assessment Tool (IPAT).



Milestone Measurement Period 1 (October 1, 2017–September 30, 2018**) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2018–September 30, 2019**) **Practice Reporting Requirement to State**
By February 28, 2018, identify the name of the integration toolkit the practice has adopted and document a practice-specific action plan informed by the practice's self-assessment, with measurable goals and timelines. By February 28, 2018, report the practice site's level of integration using the results of the IPAT level of integration tool to AHCCCS by submitting your IPAT results here.	By October 31, 2018, demonstrate substantive progress has been made on the practice-specific action plan and identify barriers to, and strategies for, achieving additional progress. By July 31, 2019, report on the progress that has been made since November 1, 2018 and identify barriers to, and strategies for, achieving additional progress.

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2. **Identify members who are at high-risk and develop an electronic registry to track those members and support effective integrated care management. Practices should consider multiple sources when identifying members at high risk, including information provided by managed care organizations (MCOs), electronic health record (EHR)-based analysis of members with distinguishing characteristics, clinical team referral and Admission-Discharge-Transfer (ADT) alerts received from Health Current (Arizona Health-e Connection. Practices should prioritize members within the registry whose status may be improved or favorably affected through practice-level care management.**[1]

The registry may be maintained inside or outside of the electronic health record.

Pediatric members at high risk are determined by the practice, but must include children/youth who a) have or are at increased risk for chronic physical, developmental, behavioral or emotional conditions and b) also require health and related services of a type or amount beyond that required by children/youth generally. This registry must also include all children/youth who have or are at risk for autism spectrum disorder (ASD) and all children/youth engaged in the child welfare system.

Milestone Measurement Period 1 (October 1, 2017–September 30, 2018**) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2018–September 30, 2019**) **Practice Reporting Requirement to State**
A. By May 31, 2018, demonstrate that a high-risk registry has been established and articulate the criteria used to identify high-risk member members. B. By September 30, 2018, demonstrate that the high-risk identification criteria are routinely used and that the names and associated clinical information for members meeting the practice criteria are recorded in the registry.	By September 30, 2019, demonstrate that the care manager is utilizing the practice registry to track integrated care management activity and member progress, consistent with Core Component 3A and/or 3B.

[1] Practices delivering primary care means the practice assumes full responsibility for meeting all the primary care needs of a group of patients seen at the practice.

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<table>
<tr><td>3.</td><td colspan="2">Utilize practice care managers[2] for members included in the high-risk registry with a case load not to exceed a ratio of 1:100. Care managers may be employed directly or contracted by the practice from external sources. Practice level care management functions should include:
1) Conducting a comprehensive assessment with the child/youth that includes family status and home environment assessment.
2) Playing an active role in developing and implementing integrated care plans. These plans should build on family strengths, plan for the transition of youth from pediatric to adult systems of care, as appropriate, and (if applicable) be developed with input from behavioral health Child and Family Teams. [3]
3) Coordinating members' medical and behavioral health services, assuring optimal communication and collaboration with MCO and/or other practice case or care management staff so that duplication in efforts does not occur and that member needs are addressed as efficiently as possible.
4) Ensuring the provision of member/family education to help build self-management skills and equipping families with the skills needed to navigate a complex health care system.
5) Working with members and their families to facilitate linkages to community organizations, including social service agencies.</td></tr>
<tr><td></td><td>Milestone Measurement Period 1
(October 1, 2017–September 30, 2018**)
(x 11)
Practice Reporting Requirement to State</td><td>Milestone Measurement Period 2
(October 1, 2018–September 30, 2019**)
(x6)
Practice Reporting Requirement to State</td></tr>
<tr><td></td><td>A. By June 30, 2018, identify at least one care manager who has been assigned to provide integrated care management for members listed in the practice high-risk registry. Indicate the caseload per care manager full-time employment (FTE).
B. By September 30, 2018, Document that the duties of the care manager include the elements of care management listed in this Core Component, and the process for prioritizing members to receive practice care management, consistent with Core Component 2.
C. By September 30, 2018, demonstrate that the care manager(s) has been trained in:
1) Comprehensive assessments of children/youth's needs, including family status, home environment assessments,
2) Using integrated care plans,
3) Member and family education, including managing chronic conditions and self-management (as appropriate), and
4) Facilitating linkages to community-based organizations, utilizing resources identified in Core Component 10.</td><td>A. Document that care managers have been trained in motivational interviewing to facilitate family engagement and self-management support, and when appropriate, child/youth engagement and self-management support.
B. Based on a practice record review of a random sample of 20 members, whom the practice has identified as having received behavioral health services during the past 12 months, attest that the care manager has documented: a) completing a comprehensive assessment, b) educating families, c) conducting motivational interviewing, d) appropriately facilitating linkages to community organizations, and e) planning for the transition of youth from pediatric to adult systems, (as appropriate), at least 85% of the time.</td></tr>
</table>

[2] Care management for children/youth may differ from that for adult populations. Pediatric care management is a patient and family-centered, assessment-driven, team-based function designed to meet the needs of pediatric patients while enhancing the caregiving capabilities of families and promoting self-care skills and independence. Care management should be proactive and family-centered and address medical, social, developmental, behavioral, educational and social/financial needs while creating strong community relationships across the continuum of care. Care managers can be located within the practice site, nearby, or remotely, and available through telephone or in person through telepresence means. A care manager must be a registered nurse with a Bachelor's degree or a Master's prepared licensed social worker. In the event the practice is unable to hire a care manager(s) with those qualifications, a licensed practical nurse or a Bachelor's prepared licensed social worker is acceptable.

[3] The Child and Family Team is used in the behavioral health setting and consists of individuals important to the child and family (for example, friends, neighbors, member of church, relatives) and may also include representatives of child-serving agencies (for example, Department of Child Safety, Department of Economic Security/Division of Developmental Disabilities).

4.	**Implement the use of an integrated care plan[4] using established data elements[5], for members identified as part of Core Component 2.**	
	Milestone Measurement Period 1 (October 1, 2017–September 30, 2018**) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2018–September 30, 2019**) **Practice Reporting Requirement to State**
	By September 30, 2018, demonstrate that the practice has begun using an integrated care plan.	Based on a practice record review of a random sample of 20 members, whom the practice has identified as having received behavioral health services during the past 12 months, attest that the integrated care plan, which includes established data elements, is documented in the electronic health record 85% of the time.

5.	**Screen all members to assess the status of common social determinants of health (SDOH), and develop procedures for intervention or referral based on the results from use of a practice-identified, structured SDOH screening tool.** **Tool examples include: the Patient–Centered Assessment Method (PCAM) , the Health Leads Screening Toolkit , the Hennepin County Medical Center Life Style Overview and the Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE).**	
	Milestone Measurement Period 1 (October 1, 2017–September 30, 2018**) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** **(October 1, 2018–**September 30, 2019**) **Practice Reporting Requirement to State**
	A. By September 30, 2018, identify which SDOH screening tool is being used by the practice. B. By September 30, 2018, develop policies and procedures for intervention or referral to specific resources/agencies, consistent with Core Component 10, based on information obtained through the screening.	Based on a practice record review of a random sample of 20 members, attest that: A. 85% of members were screened using the practice-identified screening tool. B. 85% of the time, results of the screening were contained within the integrated care plan. C. 85% of members, who scored positively on the screening tool, received appropriate intervention(s) or referral(s).

[4] An integrated care plan is one that prioritizes both physical and behavioral health needs, and reflects the patient and provider's shared goals for improved health. It includes actionable items and linkages to other services and should be updated continually in consultation with all members of the clinical team, the patient, the family, and when appropriate the Child and Family Team.
[5] Established data elements may include: problem identification, risk drivers, barriers to care, medical history, medication history, etc. AHCCCS will lead a stakeholder process to identify a set of established data elements that should be included in an integrated care plan.

6.

A. Develop communication protocols with physical health, behavioral health, and (if appropriate) developmental pediatric providers for referring members, handling crises, sharing information, obtaining consent and provider-to-provider consultation.

1) Behavioral health providers must also have protocols that help identify a member's need for follow-up physical health care with his/her primary care provider, and conduct a warm-hand off if necessary.

B. Develop protocols for ongoing and collaborative team-based care, including for both physical health and behavioral health providers to provide input into an integrated care plan, to communicate relevant clinical data and to identify whether the member has practice-level care management services provided by another provider.

C. Develop protocols for communicating with managed care organization-level care managers to coordinate with practice-level care management activities.

An example of a protocol can be found at: Riverside Protocol Example

Milestone Period Measurement Period 1 (October 1, 2017–September 30, 2018**) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2018–September 30, 2019**) **Practice Reporting Requirement to State**
A. By September 30, 2018, identify the names of providers and MCOs with which the site has developed communication and care management protocols. B. By September 30, 2018, document that the protocols cover how to: 1) Refer members, 2) Conduct warm hand-offs, 3) Handle crises, 4) Share information, 5) Obtain consent, and 6) Engage in provider-to-provider consultation.	Based on a practice record review of a random sample of 20 members whom the practice has identified as having received behavioral health services during the past 12 months, attest that a warm hand-off, consistent with the practice's protocol, occurred 85% of the time.

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7.	**Routinely screen all members at the age-appropriate time[6] for depression, drug and alcohol misuse, anxiety, developmental delays in infancy and early childhood, and suicide risk using age-appropriate and standardized tools such as, but not limited to:** **1) Depression: Patient Health Questionnaire (PHQ-2 and PHQ-9).** **2) Drug and alcohol misuse: CAGE-AID (Adapted to Include Drugs), Drug Abuse Screen Test (DAST), SBIRT.** **3) Anxiety: Generalized Anxiety Disorder (GAD 7).** **4) Developmental delays in infancy and early childhood: Parents' Evaluation of Development Status (PEDS), Ages and Stages Questionnaires (ASQ) or Modified Checklist for Autism in Toddlers-Revised (M-CHAT-R).** **5) Suicide Risk: Columbia-Suicide Severity Rating Scale (C-SSRS), Suicide Assessment Five-Step Evaluation and Triage (SAFE-T)** **6) Other AHCCCS approved screening tools.** **The practice must develop procedures for interventions and treatment, including periodic reassessment as per evidence-based recommendation. The practice must also indicate the criteria used to refer members to a community behavioral health provider for more intensive care.**	
	Milestone Period Measurement Period 1 (October 1, 2017–September 30, 2018**) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2018–September 30, 2019**) **Practice Reporting Requirement to State**
	A. By September 30, 2018, establish and implement the practice's policies and procedures for use of standardized screening tools to identify: 1) Depression, 2) Drug and alcohol misuse, 3) Anxiety, 4) Developmental delays in infancy, 5) Early childhood, cognitive, emotional and behavioral problems, and 6) Suicide risk. The policies must include which standardized tool will be used. B. By September 30, 2018, identify the policies and procedures for routinely screening members, in accordance with the AHCCCS EPSDT Periodicity Schedule for screening of children. C. By September 30, 2018, identify the practice's procedures for interventions or referrals, as the result of a positive screening. D. By September 30, 2018, attest that the results of all practice's specified screening tool assessments are documented in the electronic health record.	Based on a practice record review of a random sample of 20 members listed in the high-risk registry in the last 12 months, attest that a reassessment if clinically necessary, occurred within the evidence-based timeframe recommended, 85% of the time.

[6] Practices serving children/youth should utilize, available at https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/400/Exhibit430-1.docx. AHCCCS may revisit and update the periodicity schedule as needed.

8.	**Utilize the Arizona Opioid Prescribing Guidelines for Chronic Pain (excluding cancer, palliative and end-of-life-care) .**	
	Milestone Period Measurement Period 1 (October 1, 2017–September 30, 2018**) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2018–September 30, 2019**) **Practice Reporting Requirement to State**
	By April 30, 2018, demonstrate that all providers in the practice have been trained on the AZ guidelines for opioid prescribing.	Based on a practice record review of a random sample of 20 members, who were prescribed opioids, attest that the prescriber complied with the AZ guidelines for opioid prescribing 85% of time.

9.	**Participate in bidirectional exchange of data with Health Current, the health information exchange (i.e., both sending and receiving data), which includes transmitting data on core data set for all members to Health Current.**	
	Milestone Period Measurement Period 1 (October 1, 2017–September 30, 2018**) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2018–September 30, 2019**) **Practice Reporting Requirement to State**
	By September 30, 2018, develop and utilize a written protocol for use of Health Current Admission-Discharge-Transfer (ADT) alerts in the practice's management of high-risk members.	A. Attest that the practice is transmitting data on a core data set for all members to Health Current.[7] B. Attest that longitudinal data received from Health Current are routinely accessed to inform care management of high-risk members. C. Provide a narrative description of how longitudinal data are informing the care management of high-risk members.

10.	**Identify community-based resources, at a minimum through use lists maintained by the managed care organizations. Utilize the community-based resource list(s) and pre-existing practice knowledge to identify organizations with which to enhance relationships and create protocols for when to refer members to those resources.** **At a minimum, if available, practices should establish relationships with:** **1) Community-based social service agencies.** **2) Self-help referral connections.** **3) Substance misuse treatment support services.** **4) When age appropriate, schools, the Arizona Early Intervention Program (AzEIP) and family support services (including family−run organizations).**	
	Milestone Period Measurement Period 1 (October 1, 2017–September 30, 2018**) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2018–September 30, 2019**) **Practice Reporting Requirement to State**
	A. By September 30, 2018, identify the sources for the practice's list of community-based resources. B. By September 30, 2018, identify the agencies and community-based organizations to which the practice has actively outreached and show evidence of establishing a procedure for referring members that is agreed upon by both the practice and the community-based resource.	Document that the practice has conducted member and family experience surveys specifically geared toward evaluating the success of referral relationships, and that the information obtained from the surveys is used to improve the referral relationships.

[7] A core data set will include a patient care summary with defined data elements.

11.	**Prioritize access to appointments for all individuals listed in the high-risk registry. As applicable to the practice, specialized focus must be on:** **1) Ensuring that children/youth in the child welfare system have prioritized access to initial visits, and subsequent follow-up appointments.**	
	Milestone Measurement Period 1 (October 1, 2017–September 30, 2018**) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2018–September 30, 2019**) **Practice Reporting Requirement to State**
	N/A	Document the protocols used to prioritize access to members listed in the high-risk registry.

12.	**Develop protocols for using Trauma-Informed Care for all children/youth in the high-risk registry, which includes:** **1) How screening for trauma will be conducted, with what frequency and with which evidence-based screening tools, and** **2) How assessments or referrals for assessments will be made for children/youth who screen positive.**	
	Milestone Measurement Period 1 (October 1, 2017–September 30, 2018**) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2018–September 30, 2019**) **Practice Reporting Requirement to State**
	By September 30, 2018, demonstrate that all staff who screen for trauma and care managers have participated in an AHCCCS-identified Trauma-Informed Approach training program.	Document protocols for using a Trauma-Informed Approach to caring for all children/youth in the high-risk registry.

13.	**A. Follow Arizona-established diagnostic and referral pathways for any member that screens positive on the Modified Checklist for Autism in Toddlers-Revised (M-CHAT-R), Ages & Stages Questionnaires® (ASQ) or Parents' Evaluation of Developmental Status (PEDS) tool created by the ASD Advisory Committee.** **B. Develop communication protocols[8] and referral agreements with autism spectrum disorder (ASD) Specialized Diagnosing Providers to facilitate referral and diagnosis for members who have screened positively on the M-CHAT-R, PEDS or ASQ.**	
	Milestone Measurement Period 1 (October 1, 2017–September 30, 2018**) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2018–September 30, 2019**) **Practice Reporting Requirement to State**
	N/A	A. Based on a practice review of a random sample of 20 members screened as positive on the M-CHAT, ASQ or PEDS tool, attest that 85% were referred to the appropriate providers, consistent with the Arizona established diagnostic and referral pathways. B. Identify the name(s) of the ASD Specialized Diagnosing Providers with which the primary care or behavioral health site has developed a communication protocol and referral agreement.

[8] Communication may be facilitated with the use of telehealth.

14.	**Ensure that all pediatricians, family physicians, advanced practice clinicians and care managers complete a training program in ASD that offers continuing education credits, unless having done so within the past three years. This training should include:** **1) Recognizing and treating common co-existing conditions, and** **2) Use of a commonly accepted toolkit, such as "Caring for Children with ASD: A Resource Toolkit for Clinicians" from the American Academy of Pediatrics.**	
	Milestone Measurement Period 1 (October 1, 2017–September 30, 2018**) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2018–September 30, 2019**) **Practice Reporting Requirement to State**
	Identify the percentage (and names) of pediatricians, family physicians, advanced practice clinicians and care managers, who have been with the practice at least 12 months and who have completed an ASD training program for continuing education units (CEUs) in the last three years, and provide a Portable Document Format (PDF) of the CEU received.	Document that 85% of pediatricians, family physicians, advance practice clinicians and care managers, who have been with the practice for at least 12 months, have completed an ASD training program for CEUs in the last three years.

15.	**Develop procedures to provide information regarding parent support and other resources for families and other caregivers of children/youth with ASD, which include practice use of available resource lists.**	
	Milestone Measurement Period 1 (October 1, 2017–September 30, 2018**) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2018–September 30, 2019**) **Practice Reporting Requirement to State**
	N/A	Document the policies and procedures that guide the practice in providing information regarding parent support and other resources for families and other caregivers of children/youth with ASD.

16.	**Develop protocols for teenagers / young adults with ASD to facilitate smooth care transitions from pediatric to adult providers.**	
	Milestone Measurement Period 1 (October 1, 2017–September 30, 2018**) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2018–September 30, 2019**) **Practice Reporting Requirement to State**
	N/A	Document the policies and procedures that guide the practice in facilitating the transition of care for teenagers and young adults with ASD, who will be aging out of pediatrics and seeking care from adult primary care providers.

17.	**A. Develop a protocol for obtaining records for children/youth in the child welfare system prior to and after the first visit, which specifically prioritizes identifying the psychotropic medication history of the member. The protocol should include:** **1) Obtaining the proper consent for accessing behavioral health and substance use records, and** **2) Utilization of multiple resources to identify past medical and behavioral health providers, including the HIE, information obtained from the Arizona Department of Child Safety (DCS) case worker, and Comprehensive Medical and Dental Program (CMDP).** **B. Develop a protocol for addressing medication needs of children/youth in the child welfare system during the first visit, which includes how the practice will:** **1) Make efforts to consult with the most recent prescriber of psychotropic medication, to understand the child's baseline, response to treatment, side effects and ongoing plan of care, and** **2) Follow the American Academy of Child and Adolescent Psychiatry (AACAP)'s recommendation about the Use of Psychotropic Medications for Children and Adolescents Involved in Child-Serving Systems.[9]**	
	Milestone Measurement Period 1 (October 1, 2017–September 30, 2018**) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2018–September 30, 2019**) **Practice Reporting Requirement to State**
	N/A	A. Document protocols used for obtaining records for children/youth engaged in the child welfare system, prior to and after the first visit, and for addressing their psychotropic medication needs. B. Document protocols for addressing any medication needs of children/youth engaged in the child welfare system, consistent with this Core Component.

18.	**Practices that provide primary care must schedule office visits for children/youth in the child welfare system on the following *enhanced* EPSDT schedule:** **1) Monthly for infants birth to 6 months,** **2) Every three months for children between 6–24 months,** **3) Bi-annually for children/youth 24 months to 21 years of age.**	
	Milestone Measurement Period 1 (October 1, 2017–September 30, 2018**) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2018–September 30, 2019**) **Practice Reporting Requirement to State**
	Document policies and procedures to schedule and perform additional EPSDT visits consistent with the enhanced periodicity schedule.	Document that the practice measures gaps in well-care visits for children/youth in the child welfare system based on the enhanced EPSDT periodicity schedule.

9 www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/systems_of_care/AACAP_Psychotropic_Medication_Recommendations_2015_FINAL.pdf

19.	**A. Complete a comprehensive after-visit summary that is shared with the foster parents/guardians, the child welfare case worker and the Child and Family Team, as appropriate, to assist foster parents/guardians and case workers in following-up on referrals and recommendations. An example of a visit discharge and referral summary for families can be found here: http://downloads.aap.org/DOCHW/HFCA/DischargeForm.docx** **B. The comprehensive after-visit summary should include recommendations for foster parents/guardians to assess safety risk and monitor the child's medical or behavioral health issues at home. Parenting support should include education about the child's physical and emotional needs at the time of the initial visit and as required in follow-up visits to assist the child and family in understanding the care plan.** **C. Develop and implement a policy that the comprehensive after-visit summary should not divulge confidential information between the member and provider, particularly for teens engaged in the child welfare system. [10,11]**	
	Milestone Measurement Period 1 (October 1, 2017–September 30, 2018**) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2018–September 30, 2019**) **Practice Reporting Requirement to State**
	N/A	A. Document policies and procedures for developing and sharing comprehensive after-visit summaries with foster parents/guardians that contain referrals and recommendations, B. Document protocols for assessing risk and educating foster parents/guardians on the child's needs, and C. Document protocols that ensure confidentiality between the member and provider.

20.	**Participate in any Targeted Investment program-offered learning collaborative, training and education, relevant to this project and the provider population, and is not already required in other Core Components. In addition, utilize any resources developed or recommendations made during the Targeted Investment period by AHCCCS to assist in the treatment of AHCCCS-enrolled individuals.**	
	Milestone Period Measurement Period 1 (October 1, 2017–September 30, 2018**) **Practice Reporting Requirement to State**	**Milestone Measurement Period 2** (October 1, 2018–September 30, 2019**) **Practice Reporting Requirement to State**
	Not applicable. AHCCCS or an MCO will confirm practice site participation in training.	Not applicable. AHCCCS or an MCO will confirm practice site participation in training.

[10] See "Consent & Confidentiality in Adolescent Health Care: A Guide for the Arizona Health Practitioner. (http://www.azmed.org/resource/resmgr/Publications/2015_Adol_Consent_Conf_Bookl.pdf?hhSearchTerms=%22confidentiality%22)

[11] For additional resources for teens, see the following DBHS Practice Tools: Youth Involvement in the Arizona Behavioral Health System (www.azahcccs.gov/PlansProviders/Downloads/GM/ClinicalGuidanceTools/YouthPracticeProtocol.pdf) and Transition to Adulthood (www.azahcccs.gov/PlansProviders/Downloads/GM/ClinicalGuidanceTools/tas.pdf)

Resource Links

Core Component #1:

Organizational Assessment Toolkit (OATI)

Massachusetts Behavioral Health Integration Toolkit(PCMH)

PCBH Implementation Kit

Integrated Practice Assessment Tool (IPAT)

IPAT Assessment to Identify Level of Integration

Core component #5:

Patient–Centered Assessment Method (PCAM)

The Health Leads Screening Toolkit

Hennepin County Medical Center Life Style Overview

The Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE).

Core Component #6:

Riverside Protocol Example

Core Component #8:

Arizona Opioid Prescribing Guidelines for Chronic Pain

Core Component # 19

Discharge Form